TEXAS COMMISSION ON ALCOHOL AND DRUG ABUSE
RESEARCH BRIEFS

Characteristics of Substance Abuse Clients in the State Mental Hospitals and Clients in Community-Based Programs

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Texas Commission on Alcohol and Drug Abuse

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 TCADA is a state agency headed by six commissioners appointed by the governor. TCADA provides educational materials on substance use, develops prevention, intervention, and treatment programs, and conducts studies on the problems of substance use in Texas.

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Summary

Community-based programs will soon be responsible for treating singly diagnosed adult substance abuse clients that have traditionally been served in Texas' mental health hospitals. Although this will create a much greater demand from services, indications from available data suggest that the adults treated for substance abuse throughout the state hospital system now are not dissimilar from TCADA clients. Data on youth from the Vernon Drug Dependent Program (which will continue to be operated by TXMHMR) was compared with data on youth treated in TCADA-funded programs. Many youth currently served in the Vernon Program have psychiatric problems that make them, as a group, different from the current TCADA youth clients.

INTRODUCTION

The Legislature transferred the responsibility for treating adult clients diagnosed with substance abuse who are currently served by the state's mental health hospitals to community-based programs funded by the Texas Commission on Alcohol and Drug Abuse (TCADA)[1] effective September 1, 1993.

TCADA analyzed data from TXMHMR that contained diagnostic and demographic information on all clients served within the state mental health hospital system during fiscal year 1992. The data were divided into 3 separate groups: singly diagnosed mental health clients, dually diagnosed clients, and singly diagnosed substance abusers, with the remainder being those without any diagnosis. Singly diagnosed mental health clients are those who have a DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders [Third Edition-Revised], APA, 1987) diagnosis of some form of mental illness (*i.e.*, Schizophrenia, Major Depression, or Bipolar disorder). Dually diagnosed clients refers to those with both mental health and substance abuse diagnoses, whereas singly diagnosed substance abuse clients are those with just a substance abuse diagnosis and no additional mental health diagnosis.

The data set from TXMHMR contained records for 21,567 clients; of those, 11,463 were considered singly diagnosed with mental health problems, 3,239 singly diagnosed substance abusers and 5,923 were considered dually diagnosed. Within the dually diagnosed, forty percent (2,350) had priority diagnoses (such as Schizophrenia, Major Depression, and Bipolar disorders) that may require them to continue treatment in the state mental hospitals rather than in TCADA community-based programs. Almost 24 percent of the dually diagnosed (1,399) had a diagnosis of Schizophrenia in addition to substance abuse.

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[1] For ease of comparison, substance abusers treated in the state mental hospitals are referred to as TXMHMR clients, while those in TCADA funded community-based programs are referred to as TCADA clients.

COMPARISON OF TXMHMR SINGLY DIAGNOSED ADULTS AND TCADA ADULTS, FY92

	TXMHMR ADULTS	TCADA ADULTS
AGE (YEARS)		
Average	35.2	32.1
GENDER		
Female	22.6%	26.3%
Male	77.4%	73.7%
ETHNICITY		
Black	17.7%	30.7%
Hispanic	25.0%	24.5%
White	56.4%	43.8%
COUNTY OF RESIDENCE		
6 Metro	30.0%	50.1%
Rural	70.0%	49.9%
PRIMARY DIAGNOSIS/ PROBLEM SUBSTANCE		
Alcohol	52.8%	40.7%
Cocaine	23.1%	34.7%
Inhalants	5.6%	0.3%
Opiates	5.5%	11.5%
Marijuana	1.5%	8.8%
Polysubstance	8.5%	N/A
Other Drug	2.7%	4.0%
LENGTH OF STAY (DAYS)		
Average of Total	28.6	36.9
Alcohol	29.7	36.1
Marijuana	23.4	39.7
Inhalants	26.0	26.4
Cocaine	25.0	35.1
Opiates	22.4	47.3

PROFILE OF SINGLY DIAGNOSED ADULTS TREATED AT TXMHMR

Approximately 3,000 singly diagnosed substance abuse clients were treated at TXMHMR during fiscal year 1992. The average age of the clients was 35, and 77 percent were male. Twenty-five percent of the clients were Hispanic, 18 percent were black, and 56 percent were white. Only 30 percent of the sample resided in the six most populous counties (Bexar, Dallas, El Paso, Harris, Tarrant, and Travis), with the majority of clients living in rural counties.

Each client had from one to ten levels of DSM-III-R diagnoses. DSM-III-R levels are divided into Axis I or Axis II. Within this sample, there were from one to six diagnoses on Axis I and up to four diagnoses on Axis II. The DSM-III-R codes psychiatric syndromes (including substance abuse) and mental retardation diagnoses on Axis I, whereas personality and specific developmental disorders are coded on Axis II. The first level of diagnosis on

either axis is referred to as the primary or principal diagnosis, the second level is called the secondary diagnosis, and so forth, with the primary diagnosis being the most significant and the last diagnosis the least significant. All the clients in this sample had primary diagnoses on Axis I.

The majority of state hospital clients (53 percent) had a primary diagnosis of Alcohol Dependence/ Abuse; the second most common primary diagnosis was that of Cocaine Dependence (23 percent) followed by Polysubstance Dependence (9 percent) and Inhalant Dependence (6 percent). Clients with a primary diagnosis of Alcohol Dependence were more likely to have a secondary diagnosis of Cocaine Dependence than any other diagnosis and those with a primary diagnosis of Cocaine Dependence were more likely to have a secondary diagnosis of Alcohol Dependence than any other diagnosis. This may be due not only to the common prevalence of both substances, but may also reflect the fact that cocaine and alcohol combine to form cocaethylene, which prolongs and intensified cocaine's effects.

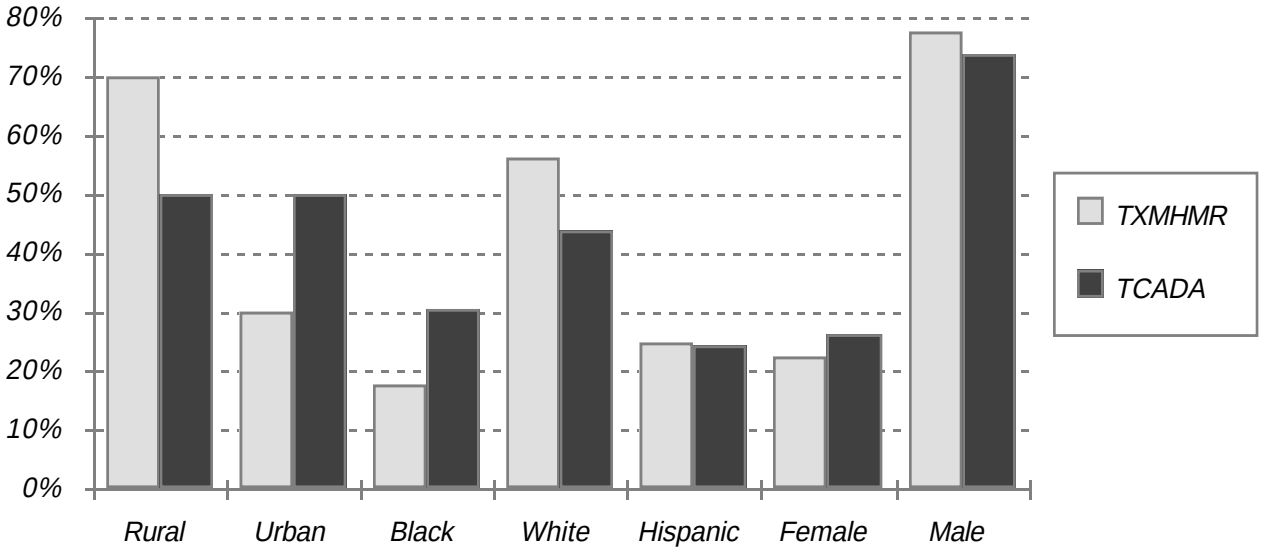
The average length of stay for state hospital substance abuse clients was 29 days but varied somewhat by primary diagnosis. Alcohol Dependence clients had the longest stay (30 days) and Opiate Dependence clients the shortest (22 days).

SINGLY DIAGNOSED TXMHMR CLIENTS COMPARED TO COMMUNITY-BASED CLIENTS

Data from TXMHMR were compared to data on clients in TCADA-funded treatment to see if TXMHMR clients differed significantly from TCADA clients. TCADA's Client Oriented Data Acquisition Process (CODAP) requires forms to be completed at admission to a TCADA-funded clinic and at follow-up 60 days after discharge from treatment. The forms, together with billing data, provide socio-demographic information as well as substance use patterns and impairment status at admission and at follow-up.

Overall the two samples were fairly similar, but TCADA clients were slightly younger (average age 32 compared to 35 in TXMHMR) and more likely to be female (26 percent in TCADA versus 23

COMPARISON OF ADULT TXMHMR AND TCADA CLIENTS

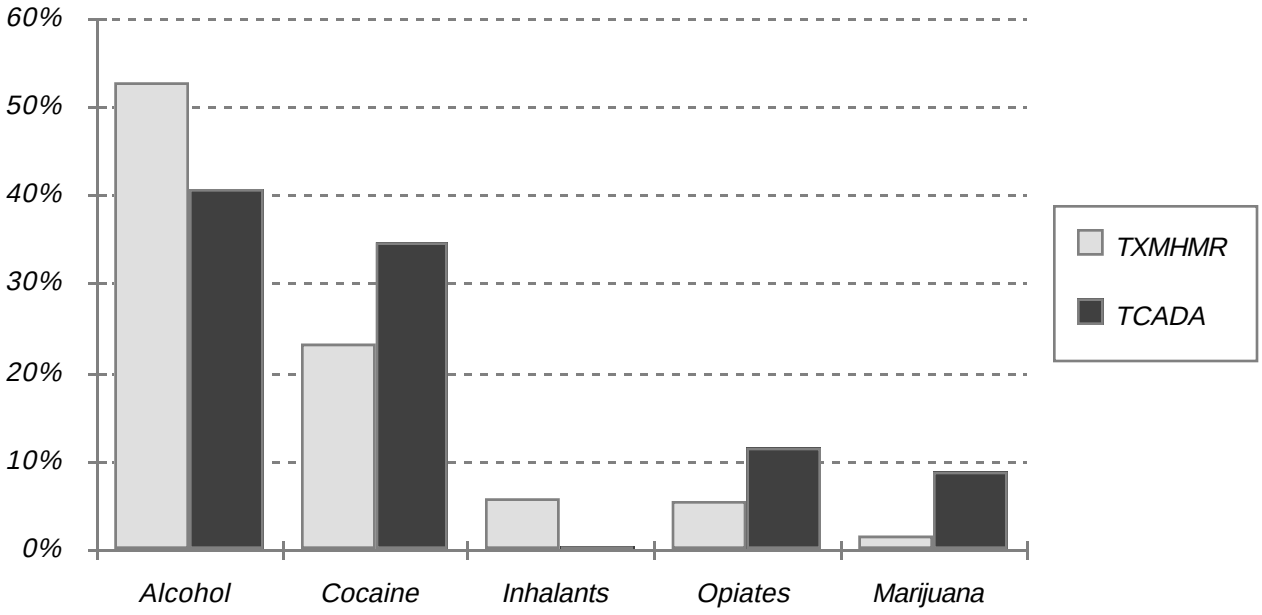


percent female in TXMHMR). One of the more interesting differences between the groups is the county of residence: only 30 percent of the TXMHMR clients resided in urban counties, whereas over 50 percent of TCADA clients were from urban counties. This may also contribute to the difference in race/ethnic distributions of the two groups, since TXMHMR had a much greater percentage of white clients (56 percent) than TCADA (44 percent). TCADA had a greater percentage of black clients (31 percent) than TXMHMR (18 percent), whereas Hispanics represented about 25 percent of the sample in both groups.

The TCADA data set looks at primary, secondary, and tertiary problem substances abused rather than diagnosis, but for simplicity the two data sets were compared as though the primary substance abused would have been the primary substance abuse diagnosis. The TXMHMR client was more likely to have a primary diagnosis of alcohol dependence, whereas the TCADA client was more likely to have a primary problem with other drugs. Clients with alcohol as the primary substance abused represented the plurality in TCADA (41 percent) but not the majority as in the TXMHMR sample (53 percent), whereas cocaine represented a much larger group in TCADA (35 percent) than it did in the TXMHMR group (23 percent). The two groups differed somewhat in inhalant, opiate, and marijuana abuse. Less than 1 percent of the TCADA sample had a primary problem of inhalant abuse, whereas inhalant abuse represented almost 6 percent of the total primary diagnoses within the state hospital group. Marijuana (9 percent) and opiate (12 percent) abusers represented a much larger segment of the TCADA client population than they did in the TXMHMR sample (2 percent and 6 percent, respectively).

TCADA clients in residential treatment had an average length of stay of 37 days per treatment episode, which is 8 days longer than the average of

COMPARISON OF ADULT TXMHMR AND TCADA CLIENTS BY PRIMARY SUBSTANCE



29 days for TXMHMR clients. The length of stay for TCADA clients with a primary problem of opiate abuse was 47 days, which was twice the length of stay in the TXMHMR group (22 days). Other problem substance groups had lengths of stay around eight to ten days longer than at TXMHMR, except for inhalant abusers who had a length of stay identical in the two groups.

PROFILE OF THE YOUTH IN TREATMENT AT THE VERNON DRUG DEPENDENT PROGRAM

In fiscal year 1992 there were 348 youth treated at the Vernon Drug Dependent Program. The typical client was 15.8 years old and 74.1 percent were male. About 41 percent of the clients were Hispanic, 10 percent were black, and 49 percent were white. Forty-nine percent of the clients were from the six most populous Texas counties (Bexar, Dallas, El Paso, Harris, Tarrant, Travis), with over 30 percent coming from Dallas and Harris counties.

The Vernon youth had diagnoses on both Axis I and Axis II but the primary diagnosis was always on Axis I, with over 95 percent of the Vernon youth having a primary diagnosis of drug or alcohol dependence or abuse. Those that did not have a primary diagnosis of substance abuse were most likely to have a diagnosis of Conduct Disorder (N=16, 5 percent), followed by Dysthymia (N=4, 1 percent), Oppositional Defiant Disorder (N=3, 1 percent), and one each of Schizoaffective Disorder, Bipolar Disorder, Adjustment Disorder, Organic Personality Disorder, and Attention Deficit Disorder. More than 95 percent of the Vernon youth had a substance abuse diagnosis on some level, with the 5 percent without a substance abuse diagnosis consisting of one client with organic personality disorder and mild mental retardation, another client with oppositional defiant disorder, and 14 clients having no diagnosis at all.

Alcohol Dependence/Abuse, the most common primary diagnosis of the Vernon youth, accounted for almost 29 percent of the total. This was followed by Marijuana Dependence/Abuse (25 percent), Inhalant Dependence/Abuse (18 percent), and Cocaine Dependence/Abuse (12 percent). The fifth most common primary diagnosis, and first non-substance abuse diagnosis, was Conduct Disorder (5 percent of the total). Conduct Disorder is characterized by a persistent pattern of conduct in which the basic rights of others are violated (DSM-III-R, APA, 1987). There are typically episodes of physical aggression or cruelty focused upon other people or animals, as well as deliberate destruction of others' property. Of those with a primary diagnosis of Conduct Disorder, 88 percent had a secondary diagnosis of Drug Dependence (such as Marijuana, Inhalant, or Polysubstance dependence) and 12 percent had a secondary diagnosis of Alcohol Dependence.

Additional primary diagnoses that occurred to a lesser degree included Polysubstance Dependence (4 percent), Hallucinogen Dependence (2 percent), Dysthymia (1 percent), and Oppositional Defiant Disorder (1 percent). In addition there were single instances of Schizoaffective Disorder, Bipolar Disorder, Adjustment Disorder, Organic Personality Disorder, and Attention Deficit Disorder.

When looking at all levels of diagnosis, including secondary and lesser diagnoses, many non-substance abuse diagnoses were found. In fact, 93 percent of Vernon youth had a secondary diagnosis for other types of mental disorders. Sixty-four percent of the Vernon youth had a diagnosis of Conduct Disorder on some level. Almost 12 percent had a diagnosis of Dysthymia, which is characterized as chronic depressed mood (or irritability) in youth. Other diagnoses, affecting as many as 8 percent of the youth, were Oppositional Defi-

COMPARISON OF VERNON DRUG DEPENDENT PROGRAM YOUTH AND TCADA YOUTH, FY92

	VERNON YOUTH	TCADA YOUTH
AGE (YEARS)		
Average	15.8	15.1
GENDER		
Female	25.9%	30.1%
Male	74.1%	69.7%
ETHNICITY		
Black	10.3%	13.1%
Hispanic	40.5%	49.5%
White	49.1%	36.5%
COUNTY OF RESIDENCE		
6 Metro	44.8%	48.3%
Rural	55.2%	51.7%
PRIMARY DIAGNOSIS/ PROBLEM SUBSTANCE		
Alcohol	31.6%	53.2%
Marijuana	27.6%	21.3%
Inhalants	19.4%	12.1%
Cocaine	13.2%	7.4%
Hallucinogens	2.3%	3.8%
LENGTH OF STAY (DAYS)		
Average of Total	115.2	67.4
Alcohol	113.8	60.2
Marijuana	111.5	70.3
Inhalants	113.3	81.4
Cocaine	103.5	74.0
Hallucinogens	118.6	65.9

ant Disorder, Developmental Disorders, and Personality Disorders. Almost 6 percent of the Vernon youth had a diagnosis of Borderline Personality Disorder that involves a chronic pattern of instability in mood, relationships, and self-image (DSM-III-R, APA, 1987).

VERNON DRUG DEPENDENT PROGRAM YOUTH COMPARED TO TCADA YOUTH

Vernon youth had more diverse substance abuse diagnoses than the TCADA youth, with more Drug Dependence diagnoses than Alcohol Dependence diagnoses. Also, Vernon youth appear to be more problematic than the TCADA youth due to the additional non-substance abuse disorders prevalent in most of the clients, and hence may require

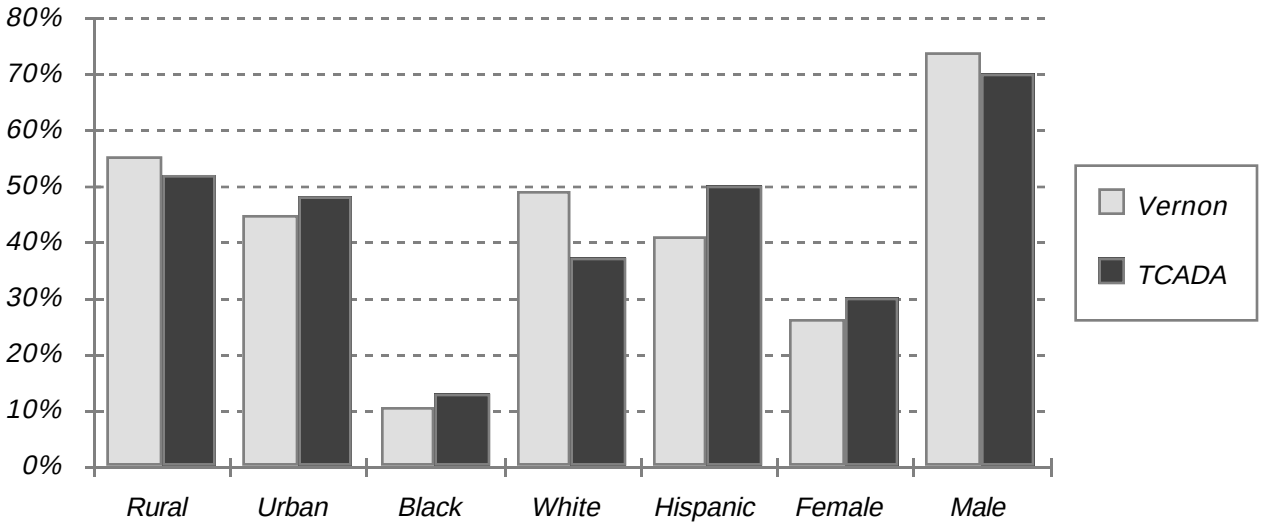
more intensive treatment.

Although Alcohol Dependence/Abuse is the most common primary diagnosis for youth at Vernon (32 percent), it does not represent the clear majority it does within the TCADA youth sample (53 percent). The majority of the Vernon youth have a non-alcohol primary diagnosis. For both groups the second most common substance abuse diagnosis is Marijuana Dependence/Abuse, followed by Inhalant Dependence/Abuse and Cocaine Dependence/Abuse, with the Vernon youth having a higher representation of each of these diagnoses than the TCADA youth who are predominately alcohol dependent.

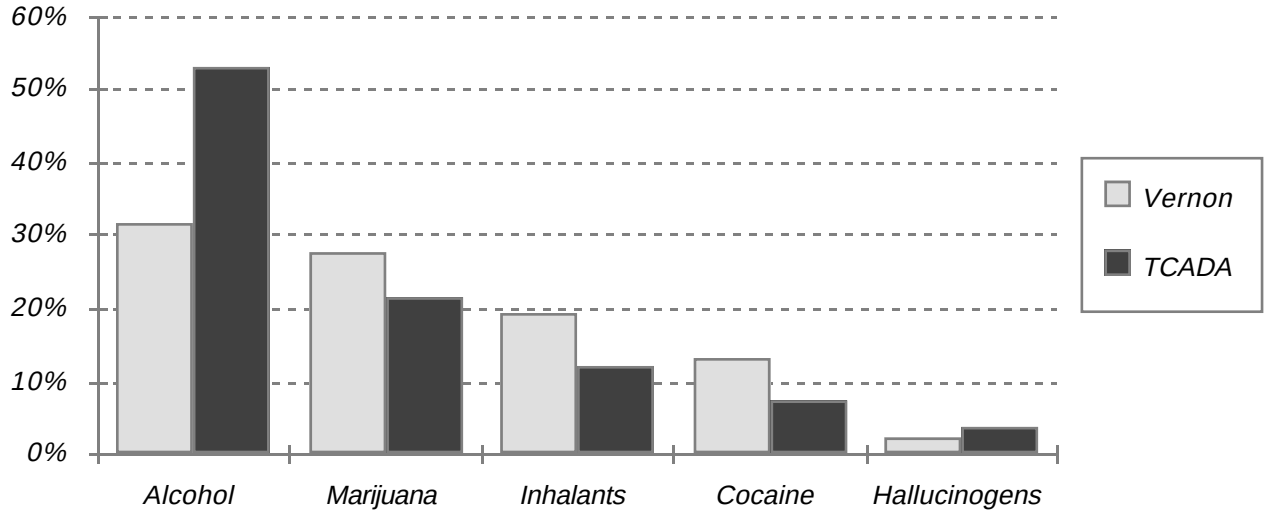
The Vernon youth were fairly similar to TCADA youth in demographics, although they were more likely to be white (49 percent Vernon versus 37 percent TCADA) and male (74 percent Vernon versus 70 percent TCADA). Vernon youth were only slightly less metropolitan than TCADA youth.

The youth at Vernon have an average length of stay more than 45 days longer than the youth in TCADA programs. Interestingly, youth in the TCADA group who have a primary alcohol problem have the shortest length of stay for treatment (60 days) whereas Vernon youth with a primary diagnosis of Alcohol Dependence have nearly the longest length of stay (114), which is almost twice as long as TCADA youth. This difference in length of stay may be partially due to the additional non-substance abuse diagnoses and time needed to treat these.

COMPARISON OF VERNON DRUG DEPENDENT PROGRAM YOUTH AND TCADA YOUTH CLIENTS



COMPARISON OF VERNON DRUG DEPENDENT PROGRAM AND TCADA YOUTH BY PRIMARY SUBSTANCE OF ABUSE



PRIMARY DIAGNOSES FOR VERNON YOUTH, FY92

Diagnosis	*Frequency*	*Percent*
Alcohol Dependence	87	26.0%
Marijuana Dependence	70	21.0%
Inhalant Dependence	53	15.9%
Cocaine Dependence	38	11.4%
Conduct Disorder	16	4.8%
Poysubstance Dependence	14	4.2%
Marijuana Abuse	14	4.2%
Alcohol Abuse	9	2.7%
Hallucinogen Dependence	8	2.4%
Inhalant Abuse	6	1.8%
Dysthymia	4	1.2%
Oppositional Defiant Disorder	3	0.9%
Amphetamine Dependence	2	0.6%
Cocaine Abuse	2	0.6%
Parent/Child Problems	2	0.6%
Opiate Dependence	1	0.3%
Schizoaffective	1	0.3%
Bipolar	1	0.3%
Adjustment Disorder	1	0.3%
Organic Personality Disorder	1	0.3%
Attention Deficit Disorder	1	0.3%

Boxed diagnoses are non-substance abuse diagnoses

INCIDENCE OF DSM-III-R DIAGNOSES IN VERNON YOUTH, FY92
ALL LEVELS OF DIAGNOSIS ON AXIS I AND AXIS II

Disorder	*Percent*	*Frequency*
Substance Dependence/Abuse	95.4%	332
Drug Dependence/Abuse	92.2%	321
Alcohol Dependence/Abuse	74.7%	260
Marijuana Dependence/Abuse	69.3%	241
Conduct Disorder	64.1%	223
Inhalant Dependence/Abuse	44.5%	155
Cocaine Dependence/Abuse	32.5%	113
Hallucinogenic Dependence/Abuse	17.5%	61
Dysthymia	11.5%	40
Nicotine Dependence/Abuse	11.2%	39
Oppositional Defiant Disorder	8.3%	29
Developmental Disorder	8.0%	28
Personality Disorder	7.8%	27
Polysubstance Dependence/Abuse	7.2%	25
Borderline Personality Disorder	5.7%	20
Organic Disorder	3.2%	11
Opiate Dependence/Abuse	2.6%	9
Organic Personality Disorder	2.0%	7
Adjustment Disorder	1.1%	4
Attention Deficit Disorder	1.1%	4
Identity Disorder	1.1%	4
Bipolar Disorder	0.6%	2
Mental Retardation	0.6%	2
Eating Disorder	0.6%	2
Schizophrenia	0.3%	1
Depression	0.3%	1
Sedative Dependence/Abuse	0.3%	1

Boxed diagnoses are non-substance abuse diagnoses